Hawaii State Hospital

AGENCY RNs:ORIENTATION CHECK-LIST

NAME _____ CHECK-LIST DUE _____

Instructions to Orientee: This form is to be completed during the first 10 shifts that you work. Return the form to the Nursing Staffing Office when completed, outside time limit:60 days.

Instructions to Orienter: Witness the Orientee demonstrating the skill or verbalizing knowledge of the subject.

Orienter Initial	Orientee Initial	Date	
			General Safety/Management of Emergencies
_____	_____	_____	Location & functioning of emergency equipment (O_2, suction, ambubag)
_____	_____	_____	Location/content emergency drug box
_____	_____	_____	Activating Code 500 Code 500 Drill
_____	_____	_____	Location of Evacuation Route map: pull alarms, extinguishers, exits, Fire Drill procedure.
_____	_____	_____	Reporting emergencies: fire, need for ambulance, police, bomb threat.
_____	_____	_____	Contacting Security, O.D., Nursing Supervisor
_____	_____	_____	Activating Code 200
_____	_____	_____	Event Report/Incident Report
_____	_____	_____	HSH Disaster Plan Location of "Life Safety Manual"
_____	_____	_____	Biohazard precautions (waste and contaminated linen)
_____	_____	_____	Location of pharmacy, laboratory, all patient care units.
_____	_____	_____	Awol/Escape protocol
_____	_____	_____	Environmental Checks

Medications

_____	_____	_____	Transcribing MD orders
_____	_____	_____	Medication set-up, administration & Documentation on MAR
_____	_____	_____	Narcotic count
_____	_____	_____	Obtaining meds after hours
_____	_____	_____	Reporting medication errors & adverse reactions
_____	_____	_____	Daily Check (11-7) of Physician Order Sheets, MARs and TARs

Shift Management

_____	_____	_____	Shift routine & activities
_____	_____	_____	Patient care assignment sheet
_____	_____	_____	Visitors:hours/guidelines
_____	_____	_____	Team Leader/Charge Nurse duties
_____	_____	_____	24 hr Nursing report (computer)
_____	_____	_____	Patient Acuity worksheet
_____	_____	_____	Use of Kardex
_____	_____	_____	Location of Policy Manuals, & other Resource books

Clinical Skills

_____	_____	_____	Admission of Patient
_____	_____	_____	Initial Care Plan
_____	_____	_____	Master Treatment Plan
_____	_____	_____	Progress notes: frequency/ Format
_____	_____	_____	Transfer process
_____	_____	_____	Discharge process
_____	_____	_____	Food/drug Interaction Education

_____ _____ _____ Special precautions: 1:1 and constant observation

_____ _____ _____ Use of Seclusion or Restraints & monitoring of patient in Seclusion and/or Restraints

Other/Misc.

_____ _____ _____

_____ _____ _____

_____ _____ _____

I have been oriented to the preceding subjects.

____ I believe that I have enough information to function safely and independently in the position of a supplemental staffing RN. I agree to seek supervision if I need clarification of policy/procedure.

____ I believe that I need more information/training on the following topics to adequately and/or safetly perform my job as a supplemental staffing RN:

_____

_____

RN Signature_____ DATE_____

****

I have reviewed the evaluation forms for this RN and believe that this RN needs more information/training in the following areas to adequately/safety function as a supplemental nurse.

_____

_____

Comments, if any _____

_____

Signature;Staffing Coordinator_____ DATE_____

Hawaii State Hospital

AGENCY LPNs:ORIENTATION CHECK-LIST

NAME _____ CHECK-LIST DUE _____

Instructions to Orientee: This form is to be completed during the first 10 shifts that you work. Return the form to the Nursing Staffing Office when completed, outside time limit:60 days.

Instructions to Orienter: Witness the Orientee demonstrating the skill or verbalizing knowledge of the subject.

Orienter Initial	Orientee Initial	Date	
			General Safety/Management of Emergencies
_____	_____	_____	Location & functioning of emergency equipment (O_2, suction, ambubag)
_____	_____	_____	Location/content emergency drug box
_____	_____	_____	Activating Code 500 & involvement in managing Code 500
_____	_____	_____	Location of Evacuation Route map: Pull alarms, extinguishers, exits, Fire Drill procedure.
_____	_____	_____	Reporting emergencies: fire, need for ambulance, police, bomb threat.
_____	_____	_____	Contacting Security, O.D., Nursing Supervisor
_____	_____	_____	Activating Code 200 & involvement in managing Code 200 scenario
_____	_____	_____	Event Report/Incident Report
_____	_____	_____	HSH Disaster Plan Location of "Life Safety Manual"
_____	_____	_____	Biohazard precautions (waste and contaminated linen)
_____	_____	_____	Location of pharmacy, laboratory, all patient care units.
_____	_____	_____	Use of Walkie-talkie
_____	_____	_____	Environmental Checks

EXHIBIT 3

Medications

_____	_____	_____	Transcribing MD orders
_____	_____	_____	Medication set-up, administration & Documentation on MAR
_____	_____	_____	Narcotic count
_____	_____	_____	Obtaining meds after hours
_____	_____	_____	Reporting medication errors & adverse reactions
_____	_____	_____	Daily Check (11-7) of Physician Order Sheets, MARs and TARs

Shift Management

_____	_____	_____	Shift routine & activities
_____	_____	_____	Patient care assignment sheet
_____	_____	_____	Visitors: hours/guidelines
_____	_____	_____	Location of Policy Manuals, & other Resource books

Clinical Skills

_____	_____	_____	Admission of Patient
_____	_____	_____	Vital signs, height/weight, I&O (& documentation of same)
_____	_____	_____	Patient Flow Sheets
_____	_____	_____	Specimen collection
_____	_____	_____	Assistance with ADLs
_____	_____	_____	Progress notes: frequency & Format
_____	_____	_____	Transfer/discharge process
_____	_____	_____	Escape/AWOL procedure
_____	_____	_____	Escort/transport of patients
_____	_____	_____	Program responsibilities: activity groups, education groups

_____	_____	_____	Special precautions: 1:1 and constant observation
_____	_____	_____	Use of Seclusion or Restraints.
_____	_____	_____	Monitoring patient in Seclusion or restraints
_____	_____	_____	Seclusion/Restraint Monitoring Form

Other/Misc.

_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been oriented to the preceding subjects.

____ I believe that I have enough information to function safely and independently in the position of a supplemental staffing LPN. I agree to seek supervision if I need clarification of policy/procedure.

____ I believe that I need more information/training on the following topics to adequately and/or safely perform my job as a supplemental staffing LPN.

LPN Signature_____ DATE_____

****

I have reviewed the evaluation forms for this RN and believe that this LPN needs more information/training in the following areas to adequately/safety function as a supplemental nurse.

_____

_____

Comments, if any _____

_____

Signature;Staffing Coordinator_____ DATE_____

Hawaii State Hospital

AGENCY PSYCH TECH ORIENTATION CHECK-LIST

Instructions to Orientee: This form is to be completed during the first 10 shifts works, and within 60 days at the outside. It can be signed off on different units and different shifts. Return the form to the Nursing Staffing Office when completed.

Instructions to Orienter: Witness the Orientee verbalizing knowledge of subject or demonstrating the skill.

Orienter Initial	Orientee Initial	Date	
			General Safety/Management of Emergencies
_____	_____	_____	Location & functioning of emergency equipment (O_2, suction, ambubag)
_____	_____	_____	Location emergency drug box
_____	_____	_____	Location of Evacuation Route map, pull alarms, extinguishers, exits
_____	_____	_____	Reporting emergencies: fire, need for ambulance, police, bomb threat.
_____	_____	_____	Fire/evacuation drills
_____	_____	_____	Activating Code 200 & involvement
_____	_____	_____	Activating Code 500 & involvement
_____	_____	_____	HSH Disaster Plan
_____	_____	_____	Environmental Checks
_____	_____	_____	Biohazard waste management Contaminated linen management
_____	_____	_____	Use of walkie-talkies
			Shift Management
_____	_____	_____	Shift routine & activities
_____	_____	_____	Patient care assignment sheet
_____	_____	_____	Visitors:hours/guidelines
_____	_____	_____	PSYCH TECH DUTIES

EXHIBIT 3

_____	_____	____	Location of policy manuals and other resource books

Clinical Skills

_____	_____	____	Admission of Patient
_____	_____	____	Vital signs, height/weight, I&O (& documentation of same)
_____	_____	____	Patient Flow Sheets
_____	_____	____	Specimen collection
_____	_____	____	Assistance with ADLs
_____	_____	____	Progress notes: frequency, and DAP Format
_____	_____	____	Transfer/discharge process
_____	_____	____	Escape/AWOL procedure
_____	_____	____	Escort/transport of patients
_____	_____	____	Program responsibilities:activity groups, education groups
_____	_____	____	Special precautions: 1:1 and constant observation
_____	_____	____	Use of Seclusion or Restraints.
_____	_____	____	Monitoring patient in Seclusion or restraints
_____	_____	____	Seclusion/Restraint MonitoringForm

Other/misc,

_____	_____	____	
_____	_____	____	
_____	_____	____	
_____	_____	____	
_____	_____	____	

I have been oriented to the preceding subjects.

____ I believe that the orientation was adequate and that I can now function safely in the position of a supplemental nurse aide. I agree to seek help and supervision when I am unclear of policy or procedure.

____ I believe that I need more information/training on the following topics to adequately perform my job as a supplemental nurse aide:

_____

_____

Signature of (aide)_____ DATE _____

****

I have reviewed the evaluation forms for this and feel that he/she needs more information/training in the following areas to adequately function as a supplemental staff

_____

_____

Comments, if any_____

_____

_____

_____

_____

Signature;Staffing Coordinator_____ DATE_____

HAWAII STATE HOSPITAL

NURSING AGENCY DOCUMENTATION FORM

DATE FORM COMPLETED: _____

NAME: _____ AGENCY: _____

(Please circle) **RN** **LPN** **PMA**

Agency Delivered Education /Evaluation

1. Infection Control: (Date Completed All 4 Topics)

   A. Blood Borne Pathogens
   B. Universal Precautions
   C. Tuberculosis
   D. Infection Control Practices

   Last PPD _____ Result: _____ X-Ray: _____ N/A
   Date Date

   Hepatitis B: (Please circle) A. Vaccine Series Completed
   B. Vaccine Declined
   C. Has neither completed nor Declined

2. Fire and Safety: (Date completed All 4 Topics) _____

   A. Electrical Safety
   B. Hazards Communication/ Right-To-Know
   C. Back Safety
   D. Fire Safety Principles

3. General Medication Test: (Date Completed and Result)
   _____ Pass N/A

4. Agency Co-ordinator _____
   Signature Date

Proof of Documentation (Copy)

Nursing License TB Clearance

Current CPR Card

Hawaii State Hospital
Agency Nursing Application for Orientation

Recent, (within the past five years) in-patient hospital psychiatric experience:

Institution/Agency
_____

*Address:*_____

Supervisor: _____ *Phone:* _____

Dates Employed: _____ *to* _____

Title: RN, LPN or PMA

Psychiatric patient care responsibilities (be specific):
_____
_____
_____
_____
_____
_____
_____

Institution/Agency
_____

*Address:*_____

Supervisor: _____ *Phone:* _____

Dates Employed: _____ *to* _____

Title: RN, LPN or PMA

Psychiatric patient care responsibilities (be specific):
_____
_____
_____
_____
_____
_____
_____

HAWAII STATE HOSPITAL
MEDICAL SERVICES UNIT

INITIAL EMPLOYEE/PERSONNEL HEALTH SCREEN

Name: _____ **Date:** _____

Job Title: _____ **Department**: _____

Date of Birth: _____ **Gender:** □ **Female** □ **Male**

Primary Physician: _____ **Phone #:** _____

Social Security Number: _____

CHILDHOOD ILLNESS/IMMUNIZATION HISTORY*

Disease or Vaccine	Had at Age	Immunized (Year)	Titer	Comments
Rubella				Proof of Immunization/Date, Results of Titer
Rubeola				Proof of Immunization X's 2/Date, Results of Titer
Mumps				Proof of Immunization/Date, Results of Titer
Chicken Pox (varicella)				Proof of Immunization X's2, titer, or Reliable history of disease
Tetanus (Td)				
Hepatitis B				Dates of 3-injection series/HbsAb or signed declination
PPD skin test Results:				Date and result
BCG				

*Written documentation from physician/health facility required. Hospital personnel responsible for the cost of blood tests/immunizations
Shaded areas required

_____ _____

Physician Signature **Date**

EXHIBIT 6